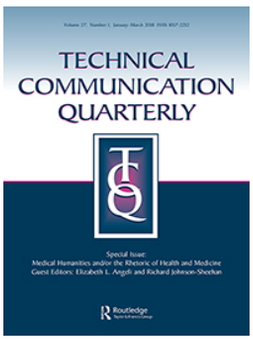

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Teaching Writing for the Health Professions: Disciplinary Intersections and Pedagogical Practice

Daniel Kenzie and Mary McCall

North Dakota State University

ABSTRACT

This article outlines an approach to teaching a Writing for the Health Professions course and situates this approach within the aims of and tensions between the medical humanities, the rhetoric of health and medicine, and disability studies. This analysis provides a pragmatic walkthrough of how assignments in such courses can be linked to programmatic outcomes (with SOAP [Subjective, Objective, Assessment, Plan] note and patient education assignments as extended examples) as well as an interdisciplinary framework for future empirical studies.

KEYWORDS

Curriculum; disability studies; healthcare writing; medical humanities; rhetoric of health and medicine

Introduction

As health professions have seen considerable growth in recent years, English departments have increasingly offered writing courses tailored to the needs of undergraduate students in the health sciences. Healthcare writing courses also present an ideal convergence point for the medical humanities, the rhetoric of health and medicine (RHM), and disability studies, as well as their common and distinctive interests. Although the medical humanities tend to use traditional methods from the humanities and social sciences to explore medical subject matter (Blease, 2016), RHM tends to examine discursive and persuasive dimensions of health, including rhetorical production as well as analysis (Scott, Segal, & Keränen, 2013). Of the three fields, disability studies has historically had the most oppositional stance toward medicine. Critiquing medical models that construct disability as a pathological deficit, disability studies instead draws attention to social and cultural dimensions of disability (Shakespeare, 2010). Operating as a nexus among these three fields, healthcare writing courses can blend humanistic concerns such as bioethics and cultural competence with writing skills and rhetorical awareness while acknowledging limitations of medical models. These multiple facets align with the goals of the medical humanities, RHM, and disability studies, respectively, offering students well-rounded preparation for health professions.

Despite the increased demand for healthcare writing courses, very little scholarship has explored such courses' theoretical underpinnings or pedagogy or how they align with or differ from courses in business or technical communication (see Assad, 2013 for one exception). Complicating this alignment is the nature of how these courses simultaneously occupy a close proximity to and distance from medical curricula; in other words, they count toward prehealth majors but are often located in English departments and taken by undergraduate students who have not fully begun their medical training. This starting place can allow for developing a course that addresses the needs of stakeholders in the health disciplines in a way that also conforms to departmental objectives and disciplinary commitments within English departments and the humanities. Although the particulars of course design must be negotiated locally, we hope to promote discussion about Writing in the Health Professions courses that supports this local decision making and begins to mark their place

CONTACT Daniel Kenzie daniel.p.kenzie@ndsu.edu North Dakota State University, Minard 316F, 1210 Albrecht Boulevard, Fargo, ND 58102, USA

within theoretical and disciplinary territories. We begin to meet this need by drawing on the evolving assignment sequence for the healthcare writing course at our former institution. By doing so, we address two larger aims: (1) to situate healthcare writing courses within the research and pedagogical aims of the medical humanities, RHM, and disability studies and (2) to offer a pragmatic discussion of implementing healthcare writing courses.

After weaving together disciplinary threads from the medical humanities, RHM, and disability studies, we cover the genres, skills, and issues common to such courses and particular to the one at our institution. We then discuss two assignments in detail: Subjective, Objective, Assessment, Plan (SOAP) notes and patient education materials. In describing these assignments, we provide a concrete example of the genres, skills, and issues that are possible in healthcare writing courses, which will benefit administrators and instructors tasked with developing such courses. Our iteration of this course may not fit all programs with different sets of learning outcomes, health majors, and institutional priorities. This variability motivates our discussion of disciplinary underpinnings, so that readers can consider not only whether our particular assignments would fit their programs, but also how the goals and insights of the medical humanities, RHM, and disability studies have bearing on local contexts. In addition, as RHM has transitioned from "emerged movement," (Scott & Meloncon, 2018, p. 3) it is time to develop its pedagogical goals, methods, and spaces. We argue that doing so at the intersections of its disciplinary cousins can benefit our students (and, ultimately, the patients and populations they hope to serve) by helping them explore the humanistic side of their work, learn practical workplace skills, and appreciate the limitations of healthcare alongside its virtues.

Rhetoric of health and medicine, medical humanities, and disability studies

Because RHM and the medical humanities are discussed in the introduction to this issue, we will only briefly describe these two fields before going into more detail about disability studies to establish the disciplinary underpinnings of healthcare writing courses. RHM is an emerging interdisciplinary field that includes scholars in technical communication, rhetoric and composition, communication studies, and related disciplines who study the mutual influence between particular patterns of language and health practices and beliefs (Meloncon & Frost, 2015; Scott et al., 2013). Evolving over the years from medical ethics as an area of study, the medical humanities (MH) offer an understanding of medicine that synthesizes biomedical knowledge about the diagnosis, treatment, and prevention of disease with ongoing critical reflection about the social, cultural, political, economic and historical dimensions of medical practices (Ahlzén, 2007; Chiapperino & Boniolo, 2014; Kirklin, 2004; Wear, 2009). Disability studies is an interdisciplinary and multidisciplinary field that considers social, cultural, and political dimensions of disability rather than treating it exclusively as individual deficit. The field is closely connected to disability activism, and its historical distinction between "impairment" as bodily or mental difference and "disability" as social oppression has undergirded many advocacy efforts. In recent years, this strict binary between impairment and disability has given way to a more complex and dynamic view of their relationship that acknowledges the importance of impairment (Shakespeare, 2010). Similarly, calls have emerged for to engage with, rather than simply oppose, medical models for disability. Introducing disability studies to medical education has become one important part of that engagement (Campbell, 2009; Couser, 2011; Khetarpal, 2012).

A key project of disability studies has been to critique problematic representations that position disability as always needing resolution through cure or individual perseverance or perpetuate stereotypes about life with a disability. Learning about the cultural representations of—and assumptions about—disability can directly impact care. As Shakespeare, Iezzoni, and Groce (2009) point out, these assumptions can have negative or even deadly consequences, giving the example that if doctors assume a person with a disability is not sexually active, they may exclude them from health information or screening for diseases such as sexually transmitted diseases (STDs), cervical cancer,

or HIV (p. 1816). McRuer's (2006) notion of compulsory able bodiedness positions these seemingly individual attitudes within larger structures that support an able-bodied world. Such a system demands that disabled people implicitly affirm that anyone would prefer to adhere to an able-bodied norm. Weaving compulsory able bodiedness with compulsory heterosexuality allows McRuer's crip theory to present disability identities as intersectional and fluid. This fluidity allows Kafer (2013) to acknowledge both disability's value to human existence and the value of health initiatives that seek to prevent or alleviate illness and impairment. That is, one need not oppose medical cures or treatment wholesale to oppose a "curative imaginary" that cannot conceive of any response to disability other than medical intervention (p. 27).

Just as Kafer (2013) suggests that the difference between promoting health and enforcing normalcy is complex and unresolved, physical therapy scholars Roush and Sharby (2011) point out that health practitioners may experience a tension between appreciating disability as diversity and alleviating pain and discomfort. One helpful idea for resolving this tension is Wendell's (2001) distinction between healthy disabled and unhealthy disabled. That is, some disabled people may have relatively stable and predictable impairments and primary challenges that are at least theoretically eliminated through social change. However, other disabled people experience significant challenges directly from their impairment and may need medical support in addition to social accommodation. Many Deaf people, for example, privilege "Deaf gain" over "hearing loss" and would see any medical intervention for their impairment as culturally destructive. However, some disabled people may welcome relief or even cure from impairments that bring them pain and suffering, even if that suffering is connected to identities or ways of being they find valuable. Goering (2015) draws on Wendell (2001) to suggest that medical professionals should listen to disabled people's experiences and not make assumptions about the source of their negative experiences (p. 136). Instead, medical professionals can resist the tendency to fear disability and instead create a space where disabled people can discuss negative aspects of their impairment without being treated as inferior. These concepts can help future health practitioners understand the wide range of relationships people can have with embodied experiences that may at first appear to be wholly negative. In this way, concepts from disability studies scholarship can not only expose students to the needs and perspectives of disabled patients, but help them better understand patient perspectives.

Disability studies shares with the medical humanities an investment in patient–provider partnership and in first-person narrative (Garden, 2010). However, there are important differences between the two fields' origins and goals. Herndl (2005) summarizes the core of these differences: disability studies grew out of activism of disabled people with the goal of "changing policies, environments, and minds," whereas the medical humanities were meant to counterbalance medical education's emphasis on science and technology, that is, to improve that status quo (p. 595). Herndl advocates collaboration between these two fields to combine the medical humanities' attention and institutional space needed to make change and disability studies' "critical consciousness" needed to ensure that change serves the needs of disabled patients and patients in general (p. 597).

Disability studies also has common interests with RHM, such as medicalization and individuals' interactions with institutional systems of power (Frost & Haas, 2017; Reynolds, 2008; Teston, 2016). Perhaps their biggest difference is in point of view. Scholarship in RHM often focuses on patients' perspectives and identities (e.g. Beemer, 2016; Segal, 2009). However, it just as often focuses on communication practices of health practitioners themselves (Angeli, 2015; Popham & Graham, 2008). In contrast, disability studies always positions disabled people as protagonists and the primary beneficiaries of research, given the field's close relationship with disability advocacy and its emphasis on disabled people's participation in actions that affect them. Thus, disability studies perspectives challenge students to think through issues of access, especially as they relate to communication, through a particular patient perspective.

Disability studies has also drawn the attention of scholars in technical communication in connection to accessibility and social justice (Browning & Cagle, 2016; Colton & Walton, 2015; Jones, Moore, & Walton, 2016; Meloncon, 2014; Oswal, 2013; Palmeri, 2006; Walters, 2010; Youngblood,

2012; Zdenek, 2015). To give an example of how disability studies can inform a technical communication classroom, both Wilson (2000) and Walters (2010) describe an activity that builds on Davis's (1995) insight that normalcy is culturally relative, historically contingent, and frequently detrimental to disabled people's lives. In this activity, students attempt to construct a normal human and choose their own criteria for doing so. As they develop and debate physical, mental, emotional, psychological, and other categories, they begin to see the impossibility of a strictly normal human, or at least begin to realize that many of them and their friends and family do not meet this standard for normalcy. Such activities can set the stage for later encounters with disability that are situated in concrete writing assignments and tasks.

Healthcare writing texts and assignments

As a site where the theoretical and pedagogical aims of the medical humanities, RHM, and disability studies can merge, courses in Writing for the Health Professions are still emerging as standalone courses apart from being a niche focus within technical communication. Previous research related to Writing for the Health Professions has examined cultivating audience awareness through peer review workshops (Assad, 2013), but no studies as of yet have outlined potential curricula of Writing for the Health Professions courses. Textbooks that adopt a rhetorical approach to healthcare writing and genres are also sparse, with the preface of Barbara Heifferon's (2005) *Writing in the Health Professions* claiming, "a text that addresses the multiple forms of writing in and for the health professions is long overdue" (p. xv). Over 10 years later, more recent healthcare writing texts still have not greatly challenged this position as they do not thoroughly address the genres particular to the healthcare professions and/or are better suited for students preparing to become technical writers rather than practitioners in these fields (Arntfield & Johnston, 2016; Bonk, 2015; Terryberry, 2004).

To explore potential texts and assignments that we could adopt in our healthcare writing courses, we searched for publically available healthcare writing syllabi on the web. We collected a total of 14 syllabi across 11 North American institutions, which included public and private research universities and 2-year colleges. These syllabi, which span from Fall 2009 to Fall 2016, have course titles that indicate some variation of Writing in (or for) the Health Professions. The courses themselves are primarily housed in English Departments, but a few come from Communication Departments or Centers for Teaching and Learning. The course texts include a range of style guides (medical-specific and more general ones), professional development guides for health professionals, textbooks on science writing and health communication, and a course pack of related readings on altruism, service, and intercultural communication. Just two syllabi adopt Heifferon's (2005) textbook, which reflects the need for more rhetoric-based texts aimed toward these courses.

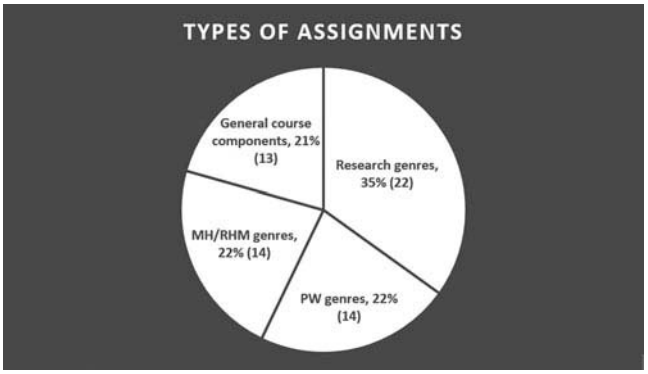


Figure 1. Breakdown of assignments in collected healthcare writing syllabi.

Because of their relatively nascent introduction to professional writing and/or technical communication programs, several of these health professions courses, perhaps unsurprisingly, lean more towards common technical communication projects than the medical humanities, RHM, and disability studies-inspired ones (see Figure 1).

Of the 63 assignments listed in this collection of syllabi, slightly more than one half (57%) were projects commonly taught within technical writing classrooms. A notable 35% of this number included research-focused assignments such as research proposals, literature reviews, a rhetorical analysis of a research article, and oral reports. The other 22% involved professional writing-focused projects such as a background and grant proposal (6%) and job document packets (16%). Meanwhile, 21% of the total number of assignments had more of a medical humanities or RHM-focus with students creating a set of patient educational materials (10%), developing a public health campaign around a campus-wide issue (6%), completing a community profile (3%), maintaining a medical blog (1%), and preparing for a debate on a health communication issue (1%). The rest of the assignments (~20%) covered more typical course components such as writing prompts about the homework (8%), end-of-the-semester portfolios (6%), and reading quizzes and exams (6%).

We should stress that our collection of syllabi was used more to tentatively assess the pedagogical pulse of healthcare writing curricula and the small sample we gathered is not representative. Nonetheless, it does suggest areas for pedagogical opportunities within Writing for the Health Professions courses, which can be verified with a more extensive empirical study. Potential directions for such a study are offered later in the conclusion of this article. Because we wanted to devise a curriculum that struck a better balance between technical writing and healthcare content, we crafted assignments that blended the aims of the medical humanities, RHM, and disability studies, which we will outline in more detail in the rest of the article.

Healthcare writing course overview

Our healthcare writing course was developed specifically to meet the needs of a new College of Health and Human Sciences. Many health sciences majors already had a requirement for an upper division writing course, but existing courses such as Business Communication and Technical Writing did not meet these needs of these students. The course was piloted as special sections of business writing in the 2013 to 2014 year and officially became a distinct course in the Department of English's Professional Writing Program in the Fall 2014 semester. McCall taught the course that year, whereas Kenzie began teaching it the following year. Most of our students were on a clinical track and planned to seek postgraduate education in fields such as medicine, dentistry, optometry, nursing, and speech pathology. Some majors, such as pharmacy and dietetics, may or may not lead to a clinical career path. A notable minority were in public health (a major with diverse concentrations such as epidemiology, environmental health, and health policy and management), and a few students planned to pursue biomedical research or medical laboratory sciences. Most clinically-bound students were primarily taking content courses in the sciences, rather than in healthcare practice, though many sought shadowing opportunities on their own. For these students, our course may have been the only course or one of the only courses students took as undergraduates that focuses on the human and professional sides of healthcare.

Like other service courses in the Professional Writing Program, our healthcare writing course provides practical experience with document design, project management, collaboration, research, writing style, and audience and context analysis, and exposure to social, ethical, and cultural dimensions of writing for work. These experiences were designed around the following programmatic learning outcomes:

- writing in context (e.g., composing in a variety of genres and media, addressing a range of audiences and stakeholders, and critically considering the ethical implications of this work)

- project management (e.g., developing and deploying various strategies for planning, researching, drafting, revising, and editing documents individually and collaboratively)
- document design (e.g., implementing design principles of format and layout and arguing with design)
- teamwork (e.g., achieving team goals and responding constructively to peers' work)
- research (e.g., locating, evaluating, and using primary and secondary sources of information)
- technology (e.g., evaluating the writing technologies frequently used in the workplace)

Although programmatic outcomes vary between institutions, this list resonates with Ilyasova and Bridgeford's (2014) proposed outcomes statement for technical communication as well as common keywords from a pilot survey of outcomes statements conducted by the Council for Programs in Technical and Scientific Communication (CPTSC) (Barker, 2012).

These learning outcomes are echoed in our assignment sequence, which asks students to begin by writing for their own professionalization (i.e., career materials), then move to writing about patients (or clients or publics), and finally, writing for other professionals (see Table 1). This sequence is also tailored to help students exercise the four core categories of medical competencies as described by the Association of American Medical Colleges (AAMC) (2017):

- interpersonal competencies (e.g., service orientation, social skills, cultural competence, teamwork, and oral communication)
- intrapersonal competencies (e.g., ethical responsibility to self and others, reliability and dependability, resilience and adaptability, and capacity for improvement)
- thinking and reasoning competencies (e.g., critical thinking and written communication)
- science competencies (e.g., human behavior).

The Professional Writing Program learning outcomes and AAMC's medical competencies already have a great deal in common, and drawing on both allowed us to adapt our expertise

Table 1. Assignment sequence in our courses.

Unit	Unit Description	Goals/Outcomes
Career materials	Students develop applications for a job or postgraduate program, including a resume or CV and a personal statement or cover letter.	1. Identify and articulate expertise. 2. Practice rhetorical concepts and document design principles. 3. Convey a consistent professional identity across multiple documents.
Clinical writing	Students write SOAP notes (a patient charting form explained in detail later in this article), often followed by a referral letter from a general practitioner to a specialist (or a reply letter from a specialist).	4. Connect written documentation to ethical patient care. 5. Distinguish subjective (patient) and objective (provider) information. 6. Balance concision and detail. 7. Write notes from interview and observational data. 8. Consider multiple authors and audiences for patient records.
Patient education	Students produce patient-centered informational materials in a genre and medium of their choice. Students also plan their materials in a proposal and discuss situated research in accessible design in a report. This assignment is sometimes sequenced with a research poster on the same topic.	9. Conduct research and adapt it for a non-specialist audience. 10. Connect health literacy to accessibility for disability and inclusive design. 11. Make rhetorically informed decisions about genre, medium, and distribution.
In-Service	Small groups deliver an instructional presentation for a workplace setting, including a posttest.	12. Consider audiences, contexts, and constraints of healthcare workplaces. 13. Practice effective instructional techniques. 14. Manage a project collaboratively. 15. Enhance oral presentation skills.

Note. CV = curriculum vitae; SOAP = Subjective, Objective, Assessment, Plan.

in technical communication to language familiar to our students, their advisors, and future employers.

Although we maintained a broadly consistent assignment sequence, other assignments included a protocol makeover, in which students redesigned a flawed clinical care protocol, and a research proposal for an empirical study.

Experienced technical communication instructors will find much that is familiar about these genres but also some important differences. For example, the in-service, a collaborative instructional presentation in a workplace, is similar to the familiar genre of instructions, differing only in its healthcare-related topics and work settings. However, protocols may reveal deeper but subtler differences when compared to technical instructions or documentation. In their study of document design and visual display in insulin protocols, Longo, Weinert, and Fountain (2007) found that the insulin protocols they studied included similar components to instructions, such as imperative voice and steps to be followed, but also tended not to include warnings or notices of potential problem areas or initial statements explaining the purpose of the procedure, and they made more extensive use of tables than typical instruction sets. Longo et al. attributed these textual differences to differences in purpose: standardizing practice instead of teaching how to perform a task (p. 448).

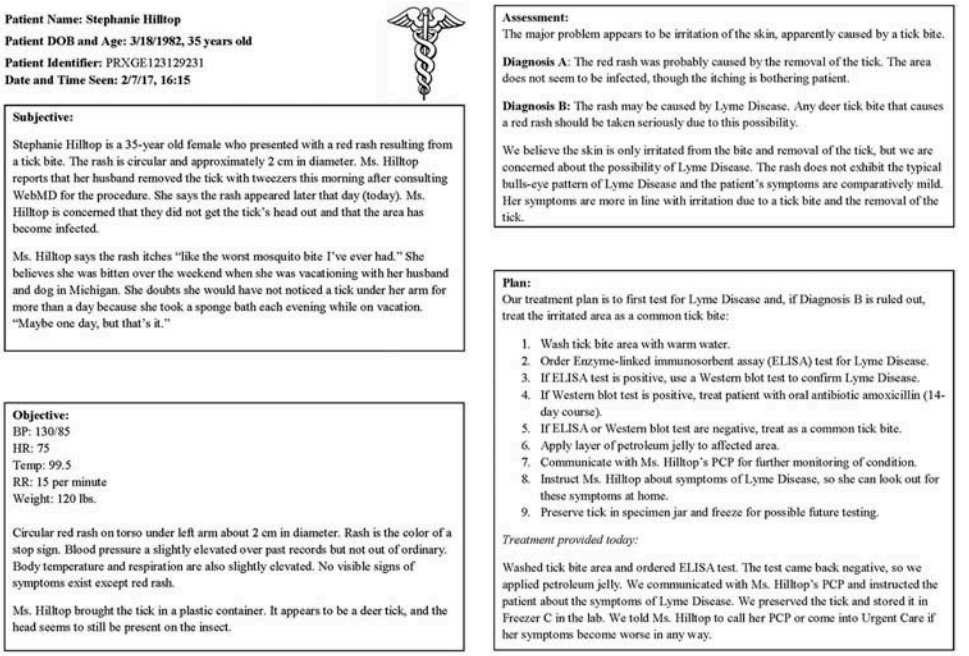
We taught career materials much as we would in a technical communication course but offered students the option of writing an application letter or a personal statement for a postgraduate application. We also consulted with a campus career specialist in health and human sciences on discipline-specific concerns. The referral letter is similar to many business letter assignments, but with rhetorical dynamics particular to comanagement of patients. Aside from major unit deliverables, our course included many familiar attendant genres, such as memos, proposals, and progress reports. Consultation with administrators, advisors, and health professionals is key to keeping these assignments current and relevant. This experience has been especially true for the SOAP note and patient education assignments. The next two sections discuss these two assignments in depth to provide a detailed discussion of implementing healthcare-specific writing genres as well as explore the multi- and interdisciplinary underpinnings of our approach to these assignments.

Project example 1: SOAP notes

Assignment description

The second unit in our healthcare writing courses focused on clinical documentation by asking students to practice writing detailed records of patients' personal histories using a type of narrative charting form—the SOAP note. The SOAP note is a problem-oriented medical record that typically begins with the subjective portion (S) that includes the chief complaint (CC), history of present illness (HPI), and past medical history (PMH) the patient gives to the provider. The objective portion (O) includes any observable information such as vital signs, physical exams, and labs obtained by the provider. The assessment portion (A) includes the provider's differential diagnosis (DDX) based on the subjective and objective data. The plan portion (P) includes next steps to be taken such as additional diagnostic tests, referrals to specialists, and patient education (see Figure 2).

Clinical documentation was selected as an assignment for this course because it helps students develop core medical competencies including thinking and reasoning (e.g., demonstrating written communication and critical thinking skills by writing detailed notes that articulate one's assessment of a patient's complaints), interpersonal skills (e.g., practicing oral communication skills through interviewing techniques), and intrapersonal skills (e.g., discussing ethical responsibility to oneself and others through conversations about ethical charting practices). In doing so, this assignment addresses the programmatic learning outcomes of writing in context (e.g., discussing the SOAP note



Patient Name: Stephanie Hilltop
Patient DOB and Age: 3/18/1982, 35 years old
Patient Identifier: PRXGE123129231
Date and Time Seen: 2/7/17, 16:15

Subjective:

Stephanie Hilltop is a 35-year old female who presented with a red rash resulting from a tick bite. The rash is circular and approximately 2 cm in diameter. Ms. Hilltop reports that her husband removed the tick with tweezers this morning after consulting WebMD for the procedure. She says the rash appeared later that day (today). Ms. Hilltop is concerned that they did not get the tick's head out and that the area has become infected.

Ms. Hilltop says the rash itches "like the worst mosquito bite I've ever had." She believes she was bitten over the weekend when she was vacationing with her husband and dog in Michigan. She doubts she would have not noticed a tick under her arm for more than a day because she took a sponge bath each evening while on vacation. "Maybe one day, but that's it."

Objective:
BP: 130/85
HR: 75
Temp: 99.5
RR: 15 per minute
Weight: 120 lbs.

Circular red rash on torso under left arm about 2 cm in diameter. Rash is the color of a stop sign. Blood pressure a slightly elevated over past records but not out of ordinary. Body temperature and respiration are also slightly elevated. No visible signs of symptoms exist except red rash.

Ms. Hilltop brought the tick in a plastic container. It appears to be a deer tick, and the head seems to still be present on the insect.

Assessment:
The major problem appears to be irritation of the skin, apparently caused by a tick bite.

Diagnosis A: The red rash was probably caused by the removal of the tick. The area does not seem to be infected, though the itching is bothering patient.

Diagnosis B: The rash may be caused by Lyme Disease. Any deer tick bite that causes a red rash should be taken seriously due to this possibility.

We believe the skin is only irritated from the bite and removal of the tick, but we are concerned about the possibility of Lyme Disease. The rash does not exhibit the typical bulls-eye pattern of Lyme Disease and the patient's symptoms are comparatively mild. Her symptoms are more in line with irritation due to a tick bite and the removal of the tick.

Plan:
Our treatment plan is to first test for Lyme Disease and, if Diagnosis B is ruled out, treat the irritated area as a common tick bite:

1. Wash tick bite area with warm water.
2. Order Enzyme-linked immunosorbent assay (ELISA) test for Lyme Disease.
3. If ELISA test is positive, use a Western blot test to confirm Lyme Disease.
4. If Western blot test is positive, treat patient with oral antibiotic amoxicillin (14-day course).
5. If ELISA or Western blot test are negative, treat as a common tick bite.
6. Apply layer of petroleum jelly to affected area.
7. Communicate with Ms. Hilltop's PCP for further monitoring of condition.
8. Instruct Ms. Hilltop about symptoms of Lyme Disease, so she can look out for these symptoms at home.
9. Preserve tick in specimen jar and freeze for possible future testing.

Treatment provided today:

Washed tick bite area and ordered ELISA test. The test came back negative, so we applied petroleum jelly. We communicated with Ms. Hilltop's PCP and instructed the patient about the symptoms of Lyme Disease. We preserved the tick and stored it in Freezer C in the lab. We told Ms. Hilltop to call her PCP or come into Urgent Care if her symptoms become worse in any way.

Figure 2. Sample SOAP note about a patient's tick bite.

as a nexus of communication between patients, practitioners, hospital staff, billing and legal teams, and other stakeholders), document design (e.g. formatting clinical documentation in a specific layout), teamwork (e.g., peer reviewing SOAP note drafts), and research (e.g. researching patient symptoms to inform differential diagnoses).

Although other forms of problem-oriented medical records exist such as DART (data, action, response, treatment), CHART (chief complaint, history of present illness, assessment, Rx/treatment, transport), and SOAPIE (subjective, objective, assessment, plan, intervention, evaluation), previous instructors of this course selected the SOAP note given its ubiquity across multiple health professions. And yet, due to the varying purviews and practices of these professions as well as methods of documentation (e.g., handwritten or electronic) across healthcare institutions, no two SOAP notes look exactly the same. Such rhetorical fluidity offers a valuable teaching opportunity in beginning this unit by asking students to bring to class examples of patient charting forms they usually find through a Google search from different professions such as physical therapy, speech therapy, dentistry, and others and analyze their similarities and differences. One former instructor used the shifting context of SOAP notes to stress the broader goals of this assignment, which was not to assume a formulaic approach to writing patient records, but to develop precise and concise writing skills that were client centered and goal directed. This strategy of teaching SOAP notes was adopted in our courses and was implemented through two parts of the assignment.

Kenzie devised the first activity, which asked students to write a detailed SOAP note based on a sample patient narrative in a clinical documentation textbook (Sullivan, 2012). Students brought their note to the next class period where they compared it against those of their classmates and discussed what information was pertinent to the CC or DDX (e.g., length of time symptoms have been present, key phrases from the patient, pain rating, etc.) and what was extraneous. The second activity stemmed from a former instructor's iteration of the assignment in which students read about how to ask open and closed questions and then practiced these skills in pairs by taking turns playing the patient who presented with a complaint (e.g., a minor illness) and the healthcare provider who

documented this information in a detailed note. These pairs conducted intake interviews two to three more times in class and presented their collection of case notes at the end of the unit to the instructor who assessed the trajectory of doctor-patient interaction as presented in the documentation.

The objective portion of the SOAP proved the largest constraint to the partner interviews as students are neither trained to perform physical exams and laboratory tests nor have the equipment to do so in the space of the writing classroom. One previous instructor responded to this constraint by providing students with readings from his clinical therapy background about how to observe nonverbal and verbal behaviors in order to document their "patient's" conduct in the objective section of their notes (Ivey, Ivey, & Zalaquett, 2013). We decided to craft scenarios similar to the patient narrative students charted in the first activity. Pairs of students received different versions of the same scenarios ahead of the interview so that the "patient" knew what their condition was and could provide additional details about their symptoms through research whereas the "provider" only knew of the chief complaint and results from hypothetical physical exams and tests performed during the intake interview. The goal behind these scenarios was not to "quiz" students on accurately guessing their "patients" condition, but to have students practice asking good questions of their "patient" and to support their clinical reasoning by providing detailed subjective and objective data.

Disciplinary connections

Threaded through these in-class activities were conversations about the ethical, political, and social dimensions of patient–provider interactions, which align with a common goal of the medical humanities of "fostering clinicians' abilities to communicate with patients, to penetrate more deeply into the patient's wider narrative, and to seek more diverse ways of promoting well being and reducing the impact of illness and disability" (Evans & Greaves, 1999, p. 1216). As students learned about the components of a SOAP note, they also read chapters from historian Keith Wailoo's 2011 book *How Cancer Crossed the Color Line* to consider the intersections among gender, race, and class regarding the history of cancer awareness and the evolution of charting and patient education practices. For one class activity, small groups read and analyzed articles about cancer from *Hygeia*, a magazine published by the American Health Association from 1923 to 1949 that Wailoo used as a primary text. Reading the same pieces Wailoo discussed, these groups considered their selected article's author, audience, purpose, style, and use of rhetorical appeals in light of Wailoo's claim that:

> [a]t the birth of cancer awareness, then, it fell on middle-class women to become exemplars of a new awareness: to show how to control fears, how to wrestle with revulsion and disgust, and how to tie middle-class maternal sensibilities to the survival of family and of the race. (p. 29)

Through access to primary sources that illuminated assumptions about cancer in the early 20th century, students could better understand how medical practices that would be deemed unethical today (e.g., not telling patients that they have cancer) were acceptable by existing cultural and social norms.

Another major text that McCall introduced to the assignment was a piece by Tauber (2006) that argues how health care practitioners can make the moral reasoning behind their clinical decision-making explicit by completing an "Ethical Concerns" section to a patient's medical record. Such an approach can work toward addressing the medical ethics debate between humanists who see moral awareness and reasoning as integrated with clinical performance and positivists who advocate for an emotionally detached, objective assessment of a patient (pp. W3–W4). In response, Tauber contends that medical practice should be a "linkage" of both: "Care cannot be administered without acknowledging the fusion of objective assessment of disease with the personal values of both the patient and the physician" (p. W5). Kenzie had the idea to have students connect this reading to a *Grey's Anatomy* clip about a doctor and two parents (one of whom is Deaf) disagreeing over their Deaf child's need for a cochlear implant. Then, the class discussed how this conversation might be documented in the child's patient record in light in Tauber's position. This activity opened discussion over whether a patient

record "functions in structuring clinical thinking" as Tauber claims (p. W7). Activities such as this one blend the medical humanities' attention to the patient–doctor relationship with disability studies' critical consciousness about disability as diversity rather than pathology and RHM's interest in how clinical records influence discourse by and about patients (for the latter, see Keränen's [2007] for an analysis of how patient preferences worksheets rhetorically shape end-of-life discussions in a clinical setting). In so doing, they encourage students to not only adhere to the legal dimensions of including pertinent details in patient records (i.e., "If it's not written down, it didn't happen"), but to also reflect on devising treatment plans that approach "a degree of common understanding between physician and patient" (Ahlzén, 2007, p. 389). This emphasis on mutuality in turn combines attention to precise writing skills with an awareness of the sociocultural factors influencing health and disease.

Students develop a rhetorical understanding of how and why SOAP notes—and health records more broadly—can vary drastically while also demonstrating patterns in how they are written. When students compare SOAP notes for their level and choice of detail, language use, and format, we emphasize the genre as "social action" that does similar work for its stakeholders' varied professions, settings, and situations (Miller, 1984). This rhetorical understanding of genre helps them consider how they will adapt their classroom experience to future professional experiences. We also briefly introduced students to the OpenNotes system, which makes health records easily available online to patients, to discuss how adding patients as an explicit audience, rather than a removed stakeholder, would impact patient involvement, the use of technical language, and patient–provider interaction, all questions taken up by Breuch, Bakke, Thomas-Pollei, Mackey, and Weinert (2016) in their study of audience involvement and OpenNotes.

The SOAP note assignment also asks students to consider the connection between formats for writing and clinical decision making and care, a link explored by RHM scholars such as Popham and Graham (2008). Tauber (2006) argues directly that "the record is more than a reflection of practice and thought, it is also a determinant of what kind of care is given, because the record functions in structuring clinical thinking" (p. W7). Students accepted or rejected this premise based on their experiences with and beyond this assignment, but we also contextualize it within a debate over whether SOAP should be reorganized into APSO (assessment, plan, subjective, objective) (i.e., move the practitioner's assessment and plan before subjective and objective data about the patient) in electronic medical records (EMRs). Proponents of APSO claim that practitioners and legal audiences are most interested in the diagnosis (assessment) and recommendations (plan), but these items are harder to find and read quickly in EMRs than paper records because they generally contain more detail and are more difficult to skim and scan (Pullen, 2010). Critics of APSO such as SOAP note creator Lawrence Weed instead claim that the APSO format makes the note more provider centered than patient centered by skipping logical reasoning and putting opinion before facts (Versel, 2014). Examples such as the APSO debate help students situate their own writing performances within arguments about how genre conventions and emerging technologies impact clinical thinking and care.

Project example 2: Patient education

Assignment description

A common assignment in healthcare writing courses in general and ours in particular is patient education materials. In our program's version of this assignment, students research a topic of their choosing and tailor that information to a document to be used by a nonspecialist audience. The typical scenario this assignment presents is a patient who has recently been diagnosed with a chronic condition and needs to understand the diagnosis and plan for its management. In addition to the topic, students also choose the genre, medium, and hypothetical setting and distribution method for their materials. For example, brochures for a clinic or hospital setting are often the first genre students think of, but other choices have included videos, games, websites, and infographics. Students may produce patient education materials in their careers, as some of our former students

have reported doing in internships, whereas others may be in a position to choose among available materials. More broadly, however, this assignment gives students practice in becoming an expert on a topic and communicating to a non-specialist audience with a concrete need and end use, a goal echoed by Assad (2013) in her description of a similar assignment (p. 121). In so doing, this assignment engages with the larger programmatic goals of writing in context, document design, research, and technology.

Because our students' advisors identified communication with nonspecialists as a high priority for the course (and we agree), patient education has been a substantial unit in our course, often taking on the role of the major unit on research and design. Because research is often a core component to technical communication classes, usually in the form of research reports, backgrounders, and proposals, we integrated discussions about using and evaluating sources in a healthcare specific context. One class activity involved a conversation about the distribution of junk science from for-profit academic articles to the media as explained in an episode about nutrition from the popular TV series *Adam Ruins Everything*. Other class activities included finding and analyzing examples as well as designing patient materials in class, then reflecting on and discussing their application of quick research, design choices, and ideas about audience and distribution. McCall also invited a biomedical sciences information specialist from the university's library to speak to the class about databases like PubMed that they could use when collecting resources for their annotated bibliographies about their selected health condition. We sometimes sequenced this assignment with others on the same topic (such as a research poster or proposal) so that students practice adapting similar information for different audiences.

Disciplinary connections

The same MH-influenced perspective about the sociocultural dimensions of medical knowledge and practices that we connected to the SOAP note assignment was also brought into the patient education one. Again, Wailoo (2011) proved an insightful historical backdrop about the evolution of the American public's understanding of cancer as conveyed through physicians' advice and the media via advertisements and public service announcements (PSAs). To have the class think more critically on the shifting historical, cultural, and social contexts of patient education materials, McCall collected and had her class watch three American Cancer Society PSAs: One from 1952 titled *Man Alive!* about cancer symptoms and treatment, a second from 1979 featuring Minne Riperton and her breast cancer diagnosis, and a third from 2011 about prostate cancer. Other class activities included student analyses of cartoons outlining the origins of the anti-vaccination debate and American magazine covers and articles related to coverage on Zika and Ebola. As we covered these topics with our students, we frequently returned to historian Leslie Reagan's argument as cited in Wailoo (2011): "'Public health educational materials do more than simply provide information. They are cultural products that participate in and produce cultural meanings as they name, describe, and depict disease'" (p. 178). This position ultimately informed our class-wide reflections on the intersections between race, class, gender, and public health issues.

Our emphasis on literacy and accessibility echoes scholars in RHM such as Kalichman (2008) who positions health literacy as central to patient education because of its connections to health outcomes and treatment adherence. In her articulation of patient experience design, Meloncon (2016) suggests technical communicators can improve health literacy by getting involved in the production of patient education materials. As Meloncon notes, health literacy can be a "catchall term" because "most healthcare professionals think they know what it means" (p. 13). Our assigned readings probe beneath this surface by introducing the scope of literacy challenges alongside tools for evaluating readability and conducting basic testing (Aldridge, 2004) and identifying a hierarchy of knowledge on a topic from foundational to advanced (Jensen, 2012). Furthermore, learning about reading strategies of people with reading challenges helps students link and distinguish varied reading challenges, which in turn helps to link literacy with accessibility for disability (Jarrett,

Redish, & Summers, 2014). In class, students practice lowering the reading level of a short but dense text and explore cultural dimensions of literacy by comparing health websites from different countries.

Our approach to accessibility with patient education continues to evolve. When the course was first piloted in 2013 and 2014, one instructor randomly assigned a "secondary complication" to each student to guide choices in accessible design. Most of these "complications" included disabilities, such as vision or hearing disabilities and cognitive disabilities, whereas others related to linguistic diversity (such as a broad "English as a second language" label), low literacy, or particular age groups (such as older adults or children). Although we saw the benefits of this approach, its impairment-specific focus also presented limitations. Walters (2010) describes the limitations of such a focus in technical communication classrooms. When her students accommodated a specific impairment in their technical descriptions and instructions, many tended to substitute one mode for another, rather than exploring more complex multimodal approaches that could accommodate a wider range of users. For example, "an audio-only description or instruction may inhibit a user with an attention disorder who may prefer a mixture of modes and more interaction" (p. 439). Her students also tended to assume that all people with disabilities experienced the same level of disability, rather than accounting for differing levels of hearing or sight or differing sensitivities among users with autism. Finally, Walters suggests that impairment-specific approaches not only respond inadequately to diverse disabilities, but also fail to build on accommodations to improve usability for the larger user base more generally.

Sharing Walters's (2010) concerns about impairment-specific approaches, McCall introduced universal design to the assignment. Universal design is an approach that builds in access needs from the start rather than as a retrofit, draws on the needs of the few to improve the needs of the many, and moves beyond checklists to attend to context-specific needs (Dolmage, 2015). In the current version of the assignment, students read about universal design, share accessibility resources with each other, and consider how their design choices impact their broader user base. In their proposal, students produce research-based user profiles and develop a methodology for achieving and evaluating accessible design and situating accessibility in their choices of audience, purpose, medium, genre, and distribution method. Then, they discuss how they implemented accessible design in an accessibility and literacy report. In one project, a student wanting to produce an educational document for children about diabetes management and nutrition tailored her documents to children with autism. With the help of a classmate with prior knowledge about autism, this student drew on autistic children's particular need for interactivity to develop an interactive activity book. In this way, she drew on disability as insight that transformed the project to the benefit of young readers who are autistic and neurotypical.

Despite such successful student projects, our approach would benefit further from direct participation from disabled users, though arranging for testing with this specific user base would pose its own challenges. Browning and Cagle (2016) address these goals and challenges through a "critical accessibility case study" assignment, which has students read accounts from disabled people about a public accessibility issue and propose solutions. Although this assignment provides students with a productive encounter with disabled people's voices, more work is needed to develop approaches to accessibility that link people's lived experience to design of applied healthcare genres. Patient education assignments are especially fruitful for this work, as communication of health information for non-specialist audiences invites attention to health literacy and accessibility.

Conclusion

Although we have outlined possible assignments for Writing for the Health Professions courses, we acknowledge that such a list is not exhaustive. One factor to take into account when designing the syllabus for any healthcare writing course is the disciplinary representation of students and their postgraduate plans. Because several health and human science majors feed into the Writing for the

Health Professions course we taught, it was common to have students from a variety of majors including premed, predentistry, preoptometry, prephysical therapy, prephysician assistant, public health, and medical laboratory sciences, among others. The percentage of students planning to apply to medical school versus those who were considering graduate school, going directly into their respective healthcare industries, or enrolling in volunteer programs like the Jesuit Volunteer Corps could also fluctuate from class to class. Thus, incorporating assignments like grant proposals work well for research-minded students, public health majors, and service-learning-oriented courses. Projects like the SOAP note or patient educational materials can also be adapted to other genres like case studies and public health campaigns to better align with students with medical laboratory or public health majors. In addition, the pedagogical direction of the course—if not immediately predicated by larger programmatic expectations—can also be influenced by the scholarly orientation of the instructors themselves. Although we have outlined how healthcare writing courses can be an amalgamation of the MH, RHM, and disability studies (DS), literature instructors may lean toward a more MH and/or DS-focused approach whereas those from Professional Writing or Technical Communication may be interested in a more RHM and/or DS-centered curriculum.

We also acknowledge that our pedagogical approach to teaching SOAP notes and patient educational materials is ongoing. Although students generally have responded positively to these opportunities to research and write about medical conditions of academic and personal interest to them, they have also offered suggestions for further improvements. Feedback from students with work experience as scribes led us to shift the SOAP notes' focus to fictional medical scenarios with time for quick preinterview research, allowing mock practitioners to develop more informed questions. As instructors, we are also interested in devising ways to make the SOAP notes assignment more collaborative as different practitioners contribute to this form of documentation in a clinical training environment. A former instructor of this course has attempted this approach by having students switch "patients" after two intake interviews and receive the documentation from their former "practitioners" to add to with a subsequent interview. Because we added the referral letter component to the SOAP note assignment, we removed this collaborative component. However, we asked students to read two CNN articles related to Thomas Eric Duncan, a Liberian citizen who was the first to die of Ebola in the United States (Shoichet, Fantz, & Yan, 2014; Yan, 2014). Because his death was largely attributed to his travel history not being properly communicated to the medical team who released him without diagnosis and treatment, these articles encourage students to reflect on and discuss the range of stakeholders involved in clinical documentation.

The patient educational materials assignment tends to be students' favorite as they often select a medical condition a family member has been diagnosed with or one they are conducting research on as part of a lab. Although students are excited to conduct further research on this condition, they often struggle at first to select an appropriate genre to communicate this information. We therefore increased students' exposure to genres other than brochures, such as infographics and children's activity books. Similarly, students do not always know how to connect accessibility to their projects, which is why it is important to expand students' research into accessibility and tie that research to rhetorically situated choices about topic, genre, audience, and design.

Although additional institution-specific accounts such as ours would enrich the field's understanding of healthcare writing pedagogy, cross-institutional empirical research is needed to put our hands on what these courses contain and aim to achieve and who they serve, nationally or internationally. A larger study of solicited syllabi beyond those publicly available, paired with a short survey, could name the most typical assignments and classify these assignments according to the disciplinary framework we have presented. It could also begin to ask questions about outcomes, assigned textbooks, typical student majors, and instructor status. Qualitative interviews would be better suited to inquire into topics such as the motivation for developing the course (e.g. long-standing partnerships with health sciences, external pressure, or the need to seek alternative revenue sources in the face of declining enrollment in English majors). These questions are vital to placing

Writing in the Health Professions within existing curricular and disciplinary frameworks, which in turn is critical if such courses continue to grow.

Finally, we believe that, despite their differing origins and goals, insights from the MH, RHM, and DS can complement and enrich one another, and that healthcare writing courses present a site for exploring their intersections and divergences. As Crick and Gabriel (2016) suggest, rhetorical theory can be aligned with narrative medicine approaches in the MH. We add that, though RHM's interest on improving communication practices exceeds the goals of the MH, it does not contradict them. Moreover, as Herndl (2005) suggests, the MH currently have institutional cache that DS (and, we add, RHM) would do well to interface with. Our healthcare writing course now counts toward a newly established MH certificate, and it remains to be seen how that connection will affect our student base and resources. Although scholars in DS have rightly feared being co-opted by applied fields (Lubet, 2004), alliances with their colleagues in the humanities can strengthen, rather than weaken, its position without losing its critical insights. Our activity about patient–provider communication and Deaf culture is just one example of how undergraduates in health majors can learn to negotiate their roles as health professionals with a recognition of disability perspectives. Pairing accessibility and health literacy in the practice of writing and design also weds goals and insights between DS and RHM. These intersections may not always be tidy. DS' political investments may bristle against the MH' relationship to medical training, and combining MH and RHM approaches may raise long-standing tensions between literature and rhetoric. However, we suggest that teaching and scholarship in all three fields can benefit from the insights of the other two, and healthcare writing courses present an ideal space for that work situated in the institutional purview and traditions of technical communication.

Notes on contributors

Daniel Kenzie is a visiting assistant professor at North Dakota State University, where he teaches scientific and technical writing. His current research focuses on discourses of traumatic brain injury in scientific research, public dialogue, and survivor experience.

Mary McCall is an assistant professor at North Dakota State University, where she teaches usability and user experience and technical writing. Her research areas include professional and technical writing, writing across the curriculum, and women's, gender, and sexuality studies, with an emphasis on the intersections between gender and identity development within engineering.

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